Wisconsin Department of Health and Family Services

Pharmacy NewsCapsule

Division of Disability and Elder Services/Bureau of Quality Assurance(BQA) July-Sept 05

Antipsychotics and Dementia Continued……

By Doug Englebert, Pharmacy Practice Consultant

The April-June 2005 edition of the Pharmacy NewsCapsule addressed a recent Food and Drug Administration (FDA) advisory on the use of antipsychotics for the treatment of dementia. The NewsCapsule article indicated that a BQA memo would be developed to address the FDA advisory. A draft of a BQA memo was developed and circulated to selected provider associations and BQA staff for comments. The memo generated very few comments. Shortly after the draft BQA memo was sent out for comments, a study was published looking at antipsychotic use in nursing homes. This study concluded that there was overuse of antipsychotics in nursing homes. In addition to this study, the Centers for Medicare and Medicaid Services (CMS) is nearing completion on updates to the State Operations Manual (SOM) specific to surveyor guidance related to pharmacy issues. Based on recent study information and upcoming changes from CMS, BQA will not be issuing a BQA memo on antipsychotics related to the recent FDA advisory.

Long term care surveyors have been directed by CMS to review antipsychotic medications used for behaviors related to dementia. Before using antipyschotics for dementia related behavior issues, the standard of practice is to first ensure: the behavior is not from some other medical, environmental, or social need or condition; the behavior is persistent; and the behavior is harmful. If the behavior meets these conditions, antipsychotic medications may be necessary. Health care providers must involve residents, families, and guardians in the care planning process, including the use of antipsychotic medication. Care planning is important to the dementia care process and involves informing residents and families about the risks and benefits of the care interventions that are available, including medications.

Investigating antipsychotic use can be difficult for surveyors. Recent publications suggest that inappropriate antipsychotic drug use and risks to the resident are still present, even with the new antipsychotics. Therefore, although difficult, it is

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Medicare Part D

By Doug Englebert, R.Ph.

What is Medicare Part D, you ask? Medicare Part D is a new drug benefit for individuals 65 or older, beginning January 1, 2006. Previously, there was no Medicare drug benefit. Individuals only had this coverage through employer health insurance plans, retirement plans, Medigap plans or, in Wisconsin, SeniorCare.

Medicare Part D will be administered by private plans called prescription drug plans or PDPs. A PDP is similar to the state employee drug plan administrator, Navitus. The PDPs must offer a standard qualifying benefit package.

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New Drugs

By Doug Englebert, R.Ph.

New Products		
Adacel	Dtap	Vaccine diphtheria, tetanus, acellular pertussis
Aptivus	Tipranavir	For HIV disease
Levemir	Insulin determir	Long-acting insulin for diabetes
Naglazyme	Galsulfase	Enzyme mucopolysaccharidosis
Rozerem	Ramelteon	Melatonin receptor for insomnia
Tygacil	Tigecycline	Antibiotic (IV)
New Forms or Uses		
BiDil	Isosorbide/hydralazine	For heart failure in self-identified black patients.

Medication Errors

Doug Englebert, Pharmacy Practice Consultant

A patient has orders for a betamethasone inhaler and an albuterol inhaler. The person administering the medications gives the betamethasone, first followed by the albuterol. The person waited the appropriate times between puffs, but shouldn't the albuterol be given first? Is this a medication error? It is true that references do indicate that for optimal effect of the inhalers the albuterol or beta agonist should be given prior to the betamethasone or steroid inhaler. This process allows the airways to open first and permits maximum absorption of the steroid into the lungs.

Is this a medication error? It depends on how you define a medication error. For regulatory purposes in a nursing home, medication errors related to technique usually involve the dosage. For example, not waiting the appropriate length of time between eye drops may not allow the full dose to reach the patient, since most of the drug runs out of the eye. In the case of albuterol and betamethasone, the full dose is reaching the patient. So for regulatory purposes, we have not counted this as a medication error. It is an issue of technique and a possible medication irregularity that needs to be reviewed by the surveyor.

Focus Drug of the Month

By Doug Englebert, R.Ph

Pain Medication Update

Duragesic® (fentanyl transdermal)

A Black Box warning exists for Duragesic that indicates serious or life threatening hypoventilation could occur. Duragesic® is contraindicated for acute pain, in the management of mild or intermittent pain, and in doses exceeding 25 micrograms per hour at the initiation of opioid therapy. The 50, 75 and 100 microgram per hour patches should ONLY be used in patients who are already on, and are tolerant to, opioid therapy.

Palladone®, Hydromorphone

The marketing of this medication was suspended due to the potential for severe side effects if this extended release product is taken with alcohol.

Methadone

Methadone is typically used for opioid addiction treatment. Limits have been placed on who can prescribe and dispense methadone. However, occasionally methadone is also used for pain treatment. Some physicians like using methadone for pain as it is long acting and cost effective. The concern with

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important to review antipsychotic use in residents with dementia. Surveyors should review: the indications for use; the monitoring of risks and benefits; involvement and decision making of resident, family members and guardians in the care plan; the dose; and if the antipsychotic used for behaviors related to dementia is removed as soon as necessary (dosage reduction).

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What are the standard benefits???

The cost for Medicare part D is:

Premium:	$35 monthly (average)
Deductible:	$250
Copay:	-25% of the total cost of the medications from $251-$2,250. -100% of the total cost of the medications from $2,251-$5,100. -$2/$5 for each prescription or 5% of the cost over $5,100.

However, if an individual's income is below 150% of the federal poverty limit deductibles, copays, etc., decrease or are eliminated. At 100% below the federal poverty limit, the payment that an individual must make is similar to the Medicaid co-payment in Wisconsin of $1 for generic drugs and $3 for brand name drugs. PDPs will be able to offer added drug benefits and collect additional premiums or charge higher copays for items not covered under the basic plan.

For residents in nursing homes who are on Medicaid and Medicare (dual eligibles, approximately 75% of WI nursing home residents), there will be no co-payments or deductibles. Surveyors will need to apply the federal nursing home pharmacy requirements as usual. Please be aware that you may see frequent medications changes after January 1st . These may not be an indication of a problem. Instead, they would be a change in benefit coverage of the medications. Additional articles will be included in future newsletters as more Medicare Part D details become available.

using methadone for geriatric patients is that methadone action can be variable, leading to accumulation and toxicity. Misinformation about methadone abounds, even suggestions that methadone cannot be used at all in nursing homes. However, that is not true. Methadone can be used in nursing homes under certain circumstances. There can be issues with coordinating opioid abuse treatment and nursing home placement. Nursing homes should plan to meet the needs of residents in treatment programs and find out what procedures are necessary to continue treatment in the facility.

Patient Controlled Analgesia (PCA)

There continues to be problems with proxy use of the PCA. Basically, doses from the PCA should only be delivered by patients themselves or by a nurse under protocol. Family members, nurses, or other staff who push the PCA button to administer a dose, thinking they are helping a patient, have caused patients to receive toxic levels of medication. PCAs are meant to be used by patients to control their own pain. Others who administer doses of pain medications based on their perception of pain may be unknowingly overdosing patients. Training, warnings systems, and even PCA pump security can minimize this problem.

If there are medications you would like featured in this column, please send an email to Doug at **engleda@dhfs.state.wi.us**

Consultant's Corner

Doug Englebert *Pharmacy Practice Consultant PRQI*

This section will appear in each issue and will contain information that will answer your questions. If there is a topic about which you want more detailed information, please drop me an email at **engleda@dhfs.state.wi.us** and I'll research the topic.

1. **How should insulin vials be stored?**

   Typically insulin in use is recommended to be stored at room temperature. At room temperature, insulin vials can typically be used for 28-30 days before the insulin needs to be destroyed. Refrigerated insulin, that is not open or not being used, is good until the manufacturers stamped date on the vial. Refrigerator temperatures need to be maintained between 36 and 46 degrees Fahrenheit. If refrigerator temperatures become too hot, insulin may need to be destroyed prior to the manufacturers stamp date. If refrigerator temperatures become too cold, causing insulin to become frozen, the insulin should be destroyed.

2. **Can a Community Based Residential Facility (CBRF) have a contingency supply?**

   A CBRF cannot have a contingency supply. In some cases, CBRFs may be attached or in the same building as a physician clinic. If that physician is caring for the CBRF residents, the physician may allow nurses to access the physician's supply of medications to meet the immediate needs of CBRF residents. This practice is considered physician dispensing.

3. **Can eye drops be used orally?**

   Occasionally, eye drops may be used in the ear or used orally. For example, for individuals with excessive salivation, atropine eye drops have been used to decrease the excessive saliva. There is literature that supports the use of an alternative route. If alternative routes for an approved medication are used, there should be literature to support the practice. Surveyors can ask facilities for the information that supports the practice they are using when there is a concern that a medication error has occurred, or adverse effects have occurred, or when there are other potential, negative, resident outcome.

4. **What medications can a hospice aide administer?**

   Hospice aides who administer medications must have taken a department-approved training program. Hospice aides who have taken the training, and will now administer medications in a hospice, work under the delegation of a registered nurse. The registered nurse determines what medications can be administered.

5. **A physician writes in the physician progress notes, or even on the physician order sheet, "Continue all meds as ordered." Is that a legal order?**

   Often a medication order list or medication administration record (MAR) is provided to a physician to review to make sure the orders are accurate. After reviewing, the physician may write "Continue all meds as ordered." This statement does not constitute a legal prescription. The note made by a physician should only relate to his or her review of the medication list. Many patient safety organizations are trying to eliminate the use of statements like the one above, because they may lead to confusion. A better practice is to provide a list of medications, or an MAR, and obtain the physician's signature or initial for each medication order.

References are available upon request.